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The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective

B. ABBOTT GOLDBERG*

*Greater than the tread of mighty armies
is an idea whose hour has come.*

Victor Hugo (attributed)

The idea whose hour has come is "Hospitals should, in short, shoulder the responsibilities borne by everyone else."¹ It is supported by two subsidiary ideas—that hospitals, even charitable hospitals, are businesses and that hospitals treat patients. "This all seems so clear on principle that one wonders why there should ever have been any doubt about it."² The purpose of this article is to explain why there was doubt and why the application of ordinary legal principles to hospitals has produced so much concern and a small library of legal comment.

The explanation will focus on one topic—the potential liability of a hospital to a patient for the negligent appointment to or retention on its medical staff of the patient's private physician, that is, liability for cor-

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1. *Bing v. Thunig*, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957).

2. *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, 360 (Denning, L.J.).

porate negligence, which is now the common expression.³ Eliminated from consideration is a hospital's liability for the negligence of its actual employees, ostensible or apparent employees, tenants such as radiologists or pathologists and emergency room contractors—persons for whose negligence the hospital may be held liable even though it was not negligent itself. Omitted are cases explainable under the doctrine of *respondeat superior* ("let the master be responsible") except insofar as these cases are explanatory of the development of the concept of the hospital's corporate negligence.

The leading case, although not the most illuminating one, *Darling v. Charleston Community Memorial Hospital*,⁴ is an illustration of hospital inattention to the enforcement of obligations imposed by law and assumed by accreditation and its own bylaws. A young athlete broke a leg playing football. He was admitted as an emergency patient and put in a cast by the private staff physician on emergency call pursuant to the hospital's medical staff bylaws.⁵ The doctor applied no padding and put the cast on too tightly. As a result of the constriction, the leg became necrotic; there were obvious symptoms such as foul odor,⁶ discoloration and loss of sensation. Despite the medical staff bylaw requiring consultation in "all major cases," none was had.⁷ After 15 days of intense suffering the lad was transferred to another hospital where, eventually, his leg was amputated.

Although the doctor settled in the ensuing litigation, the hospital went to trial on the theories that its liability as a charity was limited and that it could be held to no higher standard of care than that "customarily offered by hospitals generally in its community."⁸ The hospital lost, but the grounds on which it lost are not particularly clear. Put narrowly, the grounds were that the nurses failed to call the patient's

3. The first use of "corporate negligence" found in this connection is Note, *Torts—Hospital's Liability—Standard of Care*, 43 N.C.L. REV. 469, 471 (1965). The term seems to be derived from the effort to limit charitable immunity by distinguishing between "corporate negligence . . . in employing incompetent servants" and the "doctrine of 'respondeat superior'" imposing liability "for the negligence of . . . subordinate agents selected with care." *Roosen v. Peter Bent Brigham Hospital*, 235 Mass. 66, 126 N.E. 392, 393 (1920); Note, *Charitable Hospitals' Liability for Negligence: Abrogation of the Medical-Administrative Distinction*, 7 DUKE L.J. 127, 130 n.15 (1958). See note 30 *infra*.

4. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *aff'd* 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964).

5. 50 Ill. App. 2d at 268, 284, 200 N.E.2d at 158, 165. California requires the medical staff to have such a rule. 22 CAL. ADM. CODE §70703, ¶(g) (1975). See also, JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 24 (1982) [hereinafter cited as AMH].

6. "An odor of decaying flesh" which one witness had not smelled since World War II. 50 Ill. App. 2d at 287, 200 N.E.2d at 167.

7. *Id.* at 283, 200 N.E.2d at 165. California requires the medical staff to develop criteria for consultation. 22 CAL. ADM. CODE §70703, ¶(j) (1975). See also AMH, *supra* note 5, at 104-05 (requirement in medical staff bylaws).

8. 33 Ill. 2d at 331, 211 N.E.2d at 257; 50 Ill. App. 2d at 309, 200 N.E.2d at 177.

deteriorating condition to the attention of the hospital administration and that the hospital failed to review the doctor's work or require consultation as required by its own rules. More broadly, grounds were that the hospital's duty of care was not defined by the customs of its community.

The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.¹⁰

Tested by conventional legal rules, the resulting hospital liability was unremarkable. By 1965 charitable immunity, the proposition that a charity was not liable for the negligence of its agents, servants or employees, had been in the process of judicial abandonment for more than two decades.¹¹

Institutions should shoulder the responsibilities all other citizens bear. They should minister as others do, within the obligation not to injure through carelessness. . . .

The incorporated charity should respond as do private individuals, business corporations and others, when it does good in the wrong way.¹²

Adherence to community standards or even general standards for hospital conduct was obviously inappropriate for it would have allowed hospitals to write their own tickets.¹³ *Bing v. Thunig*,¹⁴ relied on in *Darling*, had already abolished the special immunity enjoyed by hospitals in New York but by no other employers and held a hospital liable for the negligence of its employed nurses. It was already commonplace law that violation of a statute or regulation intended for the benefit of the public was either negligence or evidence of negligence.¹⁵ The rep-

9. 33 Ill. 2d at 333, 211 N.E.2d at 258; 50 Ill. App. 2d at 306, 200 N.E.2d at 166 (the hospital administrator "knew the patient was a problem").

10. 33 Ill. 2d at 332, 211 N.E.2d at 257.

11. A catalogue by jurisdiction of the various modes and qualifications of the abolition of both charitable immunity and governmental immunity appears in 2 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶¶17.01-17.57 and *id.* 1981 Supp. 3-34.

12. *President and Dir. of Georgetown College v. Hughes*, 130 F.2d 810, 814-15, 828 (D.C. Cir. 1942) (special nurse injured by student nurse allowed recovery against hospital; the leading case on judicial abandonment of charitable immunity).

13. Note the two aspects. The "locality rule" might not apply because many communities have but one hospital, there is no other to compare it to, and, in effect, it would set its own standards. *Shilkret v. Annapolis Emergency Hospital Ass'n*, 276 Md. 187, 194, 349 A.2d 245, 253 (1975). And a hospital may not escape liability merely by doing what all other hospitals are doing. A calling may not set its own tests to the exclusion of the courts, because the whole calling may be negligent. *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932), *cited in Darling*, 33 Ill. 2d at 332, 211 N.E.2d at 257, and *S. LAW & S. POLAN, PAIN AND PROFIT* 244 (1978) (discussing *Gonzales v. Nork*).

14. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

15. *RESTATEMENT (SECOND) OF TORTS* §286 and Comment f, §288B (1965).

resentation of particular competence or the voluntary assumption of a duty of care, as by seeking and obtaining accreditation, had long been a basis of liability.¹⁶ In addition, the liability of a hospital for allowing the violation of its own rules, although a little more obscure, had been established generations before and is not a peculiarity of hospital law.¹⁷

Although somewhat obscure, in *Darling*,¹⁸ the point that a hospital may be liable for failing to review the work of a staff physician retained by a patient is, nevertheless, analytically simple. Although it had become conventional to refer to a staff physician as an independent contractor,¹⁹ the physician was not, and ordinarily still is not, an independent contractor employed by the hospital. The private staff physician who admits and cares for a private patient is not employed by the hospital in any sense, neither as an independent contractor, agent, servant nor otherwise. The physician is actually a concessionaire or licensee of the hospital—a person allowed to do his own business in the hospital to help the hospital accomplish its function of treating the patient, very much as the proprietor of an amusement park may allow the operation of various attractions by third persons. If there is any consideration paid, it is not by the owner of the facility as an employer, but rather by the concessionaire for the privilege of using the facility. Thus, a staff physician may be required to pay dues,²⁰ to participate in staff activities,²¹ and, as in *Darling*, to be available for emergencies, all as consideration for the privilege of remaining on the staff. Of course, the hospital, like any other possessor of land, is under a duty to use reasonable care to prevent harm by its concessionaires or licensees, in this case the staff physicians.²² The hospital is not analogous to a landlord or lessor of chattels. The landlord or lessor of chattels is ordinarily

16. RESTATEMENT (SECOND) OF TORTS §§299A, 323, 324A (1965); W. PROSSER, HANDBOOK OF THE LAW OF TORTS §56 at 344-47, 350 n.52 (4th ed. 1971). See *Glavin v. Rhode Island Hospital*, 12 R.I. 411, 430 (1879) (concurring opinion). See generally *James v. United States*, 483 F. Supp. 581, 584-85 (N.D. Cal. 1980) and *Coffee v. McDonnell-Douglas Corp.*, 8 Cal. 3d 551, 557-58, 503 P.2d 1366, 1370, 105 Cal. Rptr. 358, 362 (1972).

17. *Glavin v. Rhode Island Hosp.*, 12 R.I. 411, 422, 425 (1879) (intern's violation of hospital rule that he summon surgeon in difficult cases); *Collins v. Hertfordshire County Council*, [1947] 1 K.B. 598, 608-09, 614 (nurse's and pharmacist's violation of hospital rule requiring medical officer's signature on order for drugs). See generally *Dillenbeck v. City of Los Angeles*, 69 Cal. 2d 472, 481, 446 P.2d 129, 135, 72 Cal. Rptr. 321, 327 (1968) and W. PROSSER, TORTS §33, at 168 (4th ed. 1971). Cf. 33 Ill. 2d at 332, 211 N.E.2d at 257.

18. The *Darling* case is accepted authority for this proposition even though it was not stated clearly in the opinion. 33 Ill. 2d at 333, 211 N.E.2d at 258. The evidence supported the verdict on the alternative grounds of negligence of the nurses or violation of the hospital's rule on consultation.

19. *E.g.*, *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

20. Cf. *Volpicelli v. Jared Sydney Torrance Memorial Hosp.*, 109 Cal. App. 3d 242, 167 Cal. Rptr. 610 (1980).

21. AMH, *supra* note 5, at 104; 22 CAL. ADM. CODE §70703, ¶(d) (1975).

22. RESTATEMENT (SECOND) OF TORTS §§318, 344, 415 comment c (1965).

not responsible for the torts of his tenant or lessee, because the landlord or lessor is only in the business of renting, not in the business of treating.

Although it seems clear as a matter of elementary law that a hospital could be liable for its own negligence in the selection or retention of incompetent physicians on its medical staff, *Darling* was an enormous surprise to the medical and hospital community. It has been characterized as undoubtedly "the most significant medical malpractice case of the 1960's,"²³ and it created a furor with overtones continuing to this day.²⁴ A current text calls it "a hard case,"²⁵ bringing to mind the old aphorism, "Hard cases make bad law." The rejoinder to this is "Bad law makes hard cases."²⁶ The law before *Darling* was bad if judged by its lack of conformity to the law generally, its disregard of the role of modern hospitals, and its frustration of common expectations. *Darling* was a departure, "a revolutionary decree,"²⁷ but only from the judicially devised rules immunizing hospitals from liability, which rules had already been castigated as

the failure of the courts to require observance by the hospital of what would seem to be an obvious duty—to see that incompetent practitioners are not permitted the use of hospital facilities even under the heading of independent contractors.²⁸

The story of how and why hospitals were exempted from obvious duties and did not have to shoulder the responsibilities borne by everyone else began on December 9, 1870, when James McDonald, a construction worker, sustained a fractured femur. He was treated at the Massachusetts General Hospital, a charity, by a student intern supervised by a "visiting surgeon," what we would now call a staff physician. The result was unsatisfactory, and McDonald sued the hospital. He lost because the court, relying on English precedents that had been overruled, announced, for the first time in this country, the doctrine of charitable immunity.²⁹ Under this doctrine a charitable hospital would

23. W. CURRAN & E. SHAPIRO, *LAW, MEDICINE AND FORENSIC SCIENCE* 368 (3d ed. 1982).

24. Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27, 33 n.30 (1978); Dunn, *Hospital Corporate Liability: The Trend Continues*, 8 MEDICOLOGICAL NEWS, Oct. 1980, at 16. Copeland is both a hospital administrator and a lawyer and wrote from both points of view. His article is particularly comprehensive and interesting.

25. A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 411 (1978) [hereinafter cited as SOUTHWICK].

26. Hayes, *Crogate's Case: A Dialogue in ye Shades on Special Pleading Reform* in 9 W. HOLDSWORTH, *A HISTORY OF ENGLISH LAW* 423 (3d ed. 1944).

27. Note, *Hospital's Liability for Poor Medical Treatment*, 39 HOSPITALS, J.A. HOSP. A., Dec. 1, 1965, at 118. "A major disappointment . . . a potent blow."

28. Note, *Liability of Hospital for Injuries to Patients Using Hospital Facilities*, 48 YALE L.J. 81, 85 (1938).

29. McDonald v. Massachusetts Gen. Hosp., 120 Mass. 432 (1876). The like result in a simi-

not be liable for the acts of its "inferior agents" if they had been selected with due care. "[T]he funds entrusted to it are not to be diminished by such casualties" as befell the unfortunate McDonald.³⁰ Charitable immunity became a general rule in this country for many years and, since it applied in most of the cases, relieved the courts of the burden of considering the relationship between the hospital and its physicians, either staff or employed, its nurses and other professional or lay personnel.

For legal precedent on the relationship between a hospital and its staff physicians, one must look at cases when charitable immunity did not apply—actually cases in which the rules of responsibility for the acts of others were tortured to achieve the same result as the immunity. *Glavin v. Rhode Island Hospital*³¹ is the archetype. Glavin, a worker in a lumber yard, lost two fingers to a circular saw. He was treated at the hospital, a charity, by an intern, who, in violation of the hospital's rules, neglected to summon a surgeon promptly and applied a tourniquet. The delay and the procedure resulted in the amputation of Glavin's arm, and he sued the hospital. Its defense of charitable immunity was rejected. The argument from English authority contradicted rather than supported the result in *McDonald*,³² and the argument on policy was "not a question for the court but for the legislature."³³

Since it rejected the charitable immunity, the court had to consider whether the intern was a servant for whose violation of the rule the hospital was vicariously liable under *respondeat superior*. Adopting a contention in *McDonald*,³⁴ the Rhode Island Hospital argued: it "undertook merely to provide the plaintiff the shelter, food, warmth and nursing of a hospital;" it "did not undertake the duties of a surgeon in treating the plaintiff's injury, but only to place him in charge of the intern or visiting surgeon;" and, "not undertaking professional charge of the plaintiff, [it] owed him no professional duty, and would not be responsible for a breach of professional duty on the part of the in-

lar case was popularly lauded because malpractice suits against charities showed that some patients were "wholly devoid of ordinary gratitude." M. VOGEL, *THE INVENTION OF THE MODERN HOSPITAL*, BOSTON, 1870-1930 at 28 (1980).

30. 120 Mass. at 436. The exception to charitable immunity was frequently stated but seldom held. It was denied in *Roosen v. Peter Bent Brigham Hosp.*, 235 Mass. 66, 70, 126 N.E. 392, 396 (1920); Note, *supra* note 3, at 129-30 n.15. It was applied in *Norfolk Protestant Hosp. v. Plunkett*, 162 Va. 151, 173 S.E. 363 (1934) (bladder injured by vaginal douche administered by incompetent nurse). Like the "captain of the ship" doctrine, see note 88 *infra*, it served "the obvious practical purpose of cutting down an immunity that promises more harm than good." Comment, 37 HARV. L. REV. 263, 264 (1923).

31. 12 R.I. 411 (1879).

32. *Id.* at 422-23, 426-29.

33. *Id.* at 425-26.

34. 120 Mass. at 434.

tern.”³⁵ The court found it easy to imagine a case where a hospital might agree to do “no more than furnish hospital accommodations, leaving the patient to find his own physician.” The hospital would then not be liable because the physician was not its servant. But here the hospital had undertaken to select a physician. Nevertheless, the hospital was not liable because mere selection did not make the physician its servant.³⁶ The court put what can be called the helpful neighbor analogy:

If A out of charity employs a physician to attend B, his sick neighbor, the physician does not become A’s servant, and A, if he has been duly careful in selecting him, will not be answerable to B for his malpractice. The reason is that A does not undertake to treat B through the agency of the physician, but only to procure for B the services of the physician. The relation of master and servant is not established between A and the physician. And so there is no such relation between the corporation and the physicians and surgeons who give their services at the hospital. It is true the corporation has power to dismiss them, but it has this power not because they are its servants, but because of its control of the hospital where their services are rendered. They would not recognize the right of the corporation while retaining them, to direct them in their treatment of patients.³⁷

The case of the intern, however, was different. He acted not only as a physician but also, under the hospital’s rules, as the person appointed to “send for the surgeon of the day.”

Here then we have the relation of principal and agent, or master and servant. If the intern neglects to call the surgeon in the class of cases designated, his neglect is the neglect of the corporation.³⁸

And so the hospital lost and “the case was subsequently settled.”³⁹

Glavin was remarkably modern in its rejection of charitable immunity and in the concurring opinion which would have held that the hospital treated the patient and furnished a physician to him for whose competence it was responsible.⁴⁰ But these ideas were in advance of their time and disappeared for seven or eight decades. What endured from *Glavin* was the notion that hospitals were liable only for some of the acts of their employees in the course of their employment. They were liable for their “administrative” or “ministerial” acts but not for their “professional” or “medical acts” because they could not control

35. 12 R.I. at 417. *Glavin* was charged only for “board, washing, warmth, and the services of nurses and ward tenders,” \$21.47, at the rate of \$8 per week. *Id.* at 421.

36. *Id.* at 423-24.

37. *Id.* at 424. See also *id.* at 430-31 (concurring on negligent selection).

38. *Id.* at 425.

39. *Id.* at 435.

40. *Id.* at 433.

acts of the latter descriptions. If they could not control, and hence were not liable for, the "professional" or "medical" acts of employees, it followed even more certainly that they were not liable for the acts of non-employees such as private staff physicians. But although ability to control may be made the basis of liability, absence of the ability to control is not necessarily a basis for nonliability.⁴¹

At the time of *McDonald* and *Glavin* hospitals were only emerging from the period when they had been institutions primarily for sheltering the poor without a connotation of medical care.⁴² It is no coincidence that both were cases of humble laborers; they were the sort of people for whom hospitals were intended. The well-to-do were cared for at home. Only a small minority of doctors practiced in hospitals, and, as the years advanced, those who did not decried the idea that surgery should be done only in hospitals rather than on kitchen tables at home. Those who did practice in hospitals constituted a medical elite which used hospital experience for education and prestige.⁴³ It was not until the 1890's, when economic pressure forced hospitals to rely on paying patients and, therefore, on private physicians who could supply such patients, that "hospitals became more clearly defined as places for medical treatment rather than shelters for the poor and homeless."⁴⁴ Only after substantial numbers of doctors treated paying patients in hospitals did the movement for improving the quality of hospital care begin. Until then "[H]ospitals [were] in many instances walk-in garbage cans, which people entered reluctantly as a last resort before death."⁴⁵

The impetus for the improvement of the quality of hospital care must be attributed to a desire for medical excellence rather than to any legal compulsion. The impetus of the law was to encourage the private

41. See the discussion of *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, 360 *infra* at note 88.

42. The legal sense of the word hospital is a corporate foundation, endowed for the perpetual distribution of the founder's charity, in the lodging and maintenance of a certain number of poor persons, according to the regulations and statutes of the founder. Such institutions are not necessarily connected with medicine or surgery, and in their original establishment had no necessary reference to sickness or accident. *Grant Corporations* (ed. 1850) 567.

9 W. HOLDSWORTH, *A HISTORY OF ENGLISH LAW* 45 n.2 (3d ed. 1944).

43. Vogel, *The Transformation of the American Hospital, 1850-1920* in *HEALTH CARE IN AMERICA* 109, 109 (S. Reverby and D. Rosner eds. 1979). One judge recognized this in *Glavin*: In the present case the services were gratuitous to the person injured, but the agent [physician] is indirectly compensated by the corporation: *i.e.*, by the opportunities for acquiring skill, experience, reputation, and subsequent practice in the profession.

12 R.I. at 431 (concurring opinion).

44. Rosner, *Business at the Bedside: Health Care in Brooklyn, 1890-1915* in *HEALTH CARE IN AMERICA* 124 (S. Reverby and D. Rosner eds. 1979) [hereinafter cited as Rosner]. See generally M. VOGEL, *THE INVENTION OF THE MODERN HOSPITAL, BOSTON, 1870-1930* at 29 *passim*, 67 (1980).

45. Schlicke, *American Surgery's Noblest Experiment*, 106 *ARCHIVES OF SURGERY* 379 (1973).

benefactions on which the hospitals were so dependent. Thus within nine months after *Glavin*, the Rhode Island Legislature exempted charitable hospitals from liability for the negligent and even malicious acts of their officers, agents or employees—a statute not changed for almost a century.⁴⁶ And *Glavin's* denial of charitable immunity was derided by courts which refused to follow it.⁴⁷

Glavin had another effect equally devastating to the concept of hospital liability for the quality of patient care by physicians. The King's Bench in England used it as a precedent for *Hillyer v. Governors of St. Bartholomew's Hospital*.⁴⁸ *Hillyer*, in turn, became a precedent for a case of utmost importance in American law, *Schloendorff v. Society of New York Hospital*.⁴⁹ *Hillyer* and *Schloendorff* are prime examples of how the courts tinkered with the ordinary rules of responsibility to reach the result of charitable immunity in cases when it did not apply.

Hillyer, a "medical man" at "the end of his resources," a charity patient, sustained paralyzing injuries to his arms during surgery on his leg, an obvious case of negligent positioning. Present during the surgery were a "consulting surgeon," "house surgeons," "certificated nurses," and "box-carriers." All except the consulting surgeon seem to have been employees of the hospital. Nevertheless, the hospital was not held liable. The court picked up *Glavin's* helpful neighbor analogy and applied it to the nurses and house surgeons. The only duty the hospital undertook was that the patient should be treated by "experts, whether surgeons, physicians or nurses of whose professional competence the governors have taken reasonable care to assure themselves."⁵⁰ There was no evidence of improper selection,⁵¹ and the hospital was not liable "if members of its professional staff, of whose competence there is no question, act negligently towards the patient in some matter of professional care or skill. . . ."⁵² The court expanded on the distinction made in *Glavin* between the intern's role as a physician and his

46. 1880 R.I. Pub. Laws c. 802, at 107; R.I. GEN. LAWS §7-1-22 (1956), *repealed by* 1968 R.I. Pub. Laws c. 43, §2, *as amended by* R.I. GEN. LAWS §9-1-26 (Supp. 1981) (charitable hospitals liable as "at common law"). *Hodge v. Osteopathic Gen. Hosp.*, 107 R.I. 135, 136 n.2, 145, 265 A.2d 733, 735 n.22, 739 (1970) (repeal not retroactive). *Fournier v. Miriam Hospital*, 93 R.I. 299, 308, 175 A.2d 298, 302 (1961), *aff'd on rehearing*, 93 R.I. 308, 179 A.2d 578 (1962) (statute of 1880 constitutional because remedy against negligent actors preserved).

47. *Flagiello v. Pennsylvania Hosp.*, 417 Pa. 486, 499, 208 A.2d 193, 199-200 (1965) (rejecting charitable immunity, the rule for 77 years, and holding hospital liable to patient for negligence of employees). Apparently unaware of the 1880 Rhode Island statute, the Pennsylvania court lauded Rhode Island as "a state . . . with wisdom and courage in inverse proportion to its geographical size." *Id.* at 499, 208 A.2d at 199.

48. [1909] 2 K.B. 820.

49. 211 N.Y. 125, 105 N.E. 92 (1914).

50. 2 K.B. at 829.

51. *Id.* at 826, 830.

52. *Id.* at 829.

role as a messenger. The hospital could not be made liable for matters of "professional skill, in which the governors of the hospital neither can nor could properly interfere either by rule or supervision," although they might be liable for their servants' performance of "purely ministerial or administrative duties," such as attending on the wards, summoning aid (e.g., *Glavin*), or supplying food.⁵³ The question of the liability for the non-professional box-carriers was "conveniently forgotten."⁵⁴ In short:

The legal duty which the hospital authority undertakes towards a patient . . . is not the ordinary duty of a person who deals with another through his servants or agents and undertakes responsibility to that other person for damage resulting from any injury inflicted upon him by the negligence of those servants or agents.⁵⁵

Hillyer did not consider charitable immunity because, despite *McDonald*, it was not applied in England. But many years later the extraordinary exemption from ordinary duties was recognized as "a desire to relieve the charitable hospitals from liabilities which they could not afford."⁵⁶

The fear of prejudicing hospital finances was, however, an express rationale of *Schloendorff*:

A ruling would, indeed be an unfortunate one that might constrain charitable institutions, as a measure of self-protection, to limit their activities. A hospital opens its doors without discrimination to all who seek its aid. . . . In this beneficent work, it does not subject itself to liability for damages, though the ministers of healing whom it has selected have proved unfaithful to their trust.⁵⁷

Although New York recognized charitable immunity, the court had to abridge the ordinary duties to protect the hospital in *Schloendorff* because the immunity did not apply in that case. Mrs. Schloendorff claimed that she had been operated on by a "visiting physician" and a "house physician" under circumstances which should have suggested to the hospital's nurses that she had not consented. Since the trial court

53. *Id.* at 829.

54. Goodhart, *Hospitals and Trained Nurses*, 54 LAW Q. REV. 553, 556 (1938). But see 2 K.B. at 828.

55. 2 K.B. at 828-29 (emphasis added).

56. *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, 361. Goodhart, *supra* note 54, at 561, 574.

57. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. at 135, 105 N.E. at 95. By relieving a hospital of a "grave responsibility and a budgetary item [it] would have had to assume," Judge Cardozo played a "favourite among competing social forces." B. LEVY, CARDOZO AND FRONTIERS OF LEGAL THINKING 103, 104 (1938). As late as 1939 *Schloendorff* was listed among the "tort cases which illustrate his permeating influence and his wisdom in decision," particularly as delineating "the extent of immunity of eleemosynary institutions and the reasons for granting it." Seavey, *Mr. Justice Cardozo and the Law of Torts*, 52 HARV. L. REV. 372, 405, 406 (1939), reprinted in 390 YALE L.J. 390, 423, 424, and 39 COLUM. L. REV. 20, 53, 54 (1939). But "In lapidary inscriptions a man is not upon oath." 2 J. BOSWELL, LIFE OF JOHNSON 407 (Apr. 7, 1775).

had directed a verdict for the hospital, "her narrative, even if improbable, must be taken as true."⁵⁸ Thus Mrs. Schloendorff was the victim of a battery, an intentional tort. Charitable immunity did not apply to intentional torts, and without it the court, as in *Glavin* and *Hillyer*, had to consider the relationship between the hospital and its staff physicians and employees. Judge Cardozo, then on the Court of Appeals for but three months, relied on *Glavin* as extended by *Hillyer* and articulated it further:

[T]he true ground for the defendant's exemption from liability is that the relation between a hospital and its physicians is not that of master and servant. The hospital does not undertake to act through them, but merely to procure them to act on their own responsibility.⁵⁹ The wrong was not that of the hospital; it was that of physicians, who were not the defendant's servants, but were pursuing an independent calling, a profession sanctioned by solemn oath, and safeguarded by stringent penalties. If, in serving their patient, they violated her commands, the responsibility is not the defendant's; it is theirs. There is no distinction in that respect between the visiting and the resident physicians. Whether the hospital undertakes to procure a physician from afar, or to have [one] on the spot, its liability remains the same.⁶⁰

It is true I think, of nurses, as of physicians, that in treating a patient, they are not acting as servants of the hospital. . . . The hospital undertakes to procure for the patient the services of a nurse. It does not undertake, through the agency of nurses, to render those services itself. The reported cases make no distinction in that respect between the position of a nurse and that of a physician . . . and none is justified in principle.⁶¹

Judge Cardozo recognized the possible liability for negligent selection of the physician as an independent contractor and for negligence of nurses in relation "to the administrative conduct of the hospital," but he did not develop these because they were not shown by the record.⁶²

In *Schloendorff* the hospital had selected the physician but, nevertheless, escaped liability. Had the patient chosen her own doctor the case would have been even stronger, for according to *Glavin*:

It is quite conceivable that a corporation might not agree to do more than furnish hospital accommodations, leaving the patient to find his own physician or surgeon. In such a case the corporation would

58. 211 N.Y. at 128, 105 N.E. at 93. Nevertheless, Cardozo seems to have disbelieved the plaintiff. "[I]f we are to credit the plaintiff's narrative." *Id.* at 131, 105 N.E. at 94.

59. *Id.* at 130, 105 N.E. at 94.

60. *Id.* at 131-32, 105 N.E. at 94 (citations omitted).

61. *Id.* at 132, 105 N.E. at 94.

62. *Id.* at 129, 105 N.E. at 93 (care in selection); *Id.* at 132, 105 N.E. at 94 (administrative conduct "not established by this record").

plainly not be liable for the torts of the physicians or surgeons, for in such a case they would not be its servants and it would not have assumed any responsibility in their selection.⁶³

When coupled with cases such as *Hillyer* and *Schloendorff* what had been only "conceivable" in *Glavin* turned into common understanding among both lawyers and doctors. Lawyers described a hospital as "really not much more than a specialized hotel" or workshop where a doctor chosen by the patient could do as he saw fit without subjecting the hotelier or proprietor of the workshop to any liability for the quality of the physicians' care.⁶⁴ The attitude of doctors was the same. A surveyor for the American College of Surgeons in 1917 reported they considered a hospital

a more convenient place . . . than the home in which to perform an operation and for the patient to remain during his convalescence. The hospital's sole obligation was to furnish space with proper heat, light and food for the patient. When these services were paid for by the patient and he was discharged, the hospital's interest and obligation to the patient ceased.⁶⁵

This is almost a paraphrase of the hospital's argument in *Glavin*.⁶⁶

But change was in the wind. Dr. Ernest Amory Codman of Boston, a man of astonishing prescience, had already recognized that "charitable hospitals have become businesses . . ." ⁶⁷—an idea that was not to begin to be generally accepted by the courts for some thirty-five years.⁶⁸

Dr. Codman was to serve as a precursor of legal thinking in another way. He was the "grand-daddy of efforts in quality of care evaluation in this country."⁶⁹ In 1913 he told the Philadelphia County Medical

63. *Glavin v. Rhode Island Hosp.*, 12 R.I. at 423.

64. *Alden v. Providence Hospital*, 382 F.2d 163, 166 (D.C. Cir. 1967) (Berger, J., dissenting, "a hostel with special services" but no diagnostic function). The analogy has also been stated only to disagree with it: *Fridena v. Evans*, 127 Ariz. 516, —, 622 P.2d 463, 465 (1980) ("a physical structure and furnishings in which physicians practiced their art"); *Smith v. Duke Univ. Hosp.*, 219 N.C. 628, 634, 14 S.E.2d 643, 647 (1941) (hospital only a provider of room and board); *Yepremian v. Scarborough General Hospital*, 88 D.L.R.3d 161, 172 (Ont. 1978) (a "specialized kind of hotel" if physician is private but not if employed); Koskoff and Nadeau, *Hospital Liability: The Emerging Standard of Care*, 48 CONN. B.J. 305, 309 (1974) (more than a hotel or workshop); S. LAW & S. POLAN, PAIN AND PROFIT 54 (1978) (hotel for the sick, workshop for physician); SOUTHWICK, *supra* note 25, at 346 ("a mere facility or hotel . . . a 'doctor's workshop'"). But see even the defense testimony in *Darling*:

[A] hospital is more than just bricks and mortar [T]he governing board is responsible for the proper care of the patient . . . it has the power to choose the standard of medicine that will be practiced in its hospital

50 Ill. App. 2d at 300, 200 N.E.2d at 173.

65. L. DAVIS, FELLOWSHIP OF SURGEONS 205 (1960) [hereinafter cited as L. DAVIS].

66. 12 R.I. at 417.

67. Rosner, *supra* note 44, at 124. "[T]oday's hospital . . . operates . . . in a businesslike fashion." *Bing v. Thunig*, 2 N.Y.2d 656, 664, 143 N.E.2d 3, 7, 163 N.Y.S.2d 3, 9 (1957).

68. See notes 11, 12 *supra*.

69. S. JONAS, MEDICAL MYSTERY 147 (1978). The idea of review did not originate with Codman. It had been suggested as early as 1732. *Id.* Dr. John Gregory, professor of medicine at Edinburgh and author of a work on medical ethics, suggested independent reviewers in 1770. J.

Society that the main product of a hospital was the patient who had been treated there and that the skill of a hospital's staff could be judged only by the "common sense notion that every hospital should follow every patient it treats, long enough to determine whether or not the treatment has been successful and then to inquire, if not, why not?"⁷⁰ What is important to note here is that at the time Judge Cardozo was announcing as a matter of law that hospitals merely procured physicians for the patient to act on their own responsibility,⁷¹ the workshop idea, Dr. Codman was recognizing that a hospital treated a patient—an idea that was resisted by courts as late as 1967.⁷²

Dr. Codman's efforts were initially unsuccessful. He was branded an eccentric and had to leave the Massachusetts General Hospital and establish his own hospital to develop a systematic means of evaluating what he called "end-results."⁷³ A survey for the American College of Surgeons in 1918 showed that only 89 of 692 hospitals investigated could meet even the simplest requirements, a statistic so embarrassing that the report was suppressed and the printed copies were destroyed.⁷⁴

Nevertheless, in 1919 the American College of Surgeons, in an effort to create an organization "devoted completely to the evaluation of professional and hospital standards which would benefit the patient," adopted its "minimum standard" that each hospital have an organized staff of competent physicians who would adopt rules governing their

BERLANT, PROFESSION AND MONOPOLY 88, 92 (1975). But Percival's Medical Ethics became dominant in this country, and they called only for moral sanctions and left "accountability for mistakes to individual conscience rather than collective professional action." *Id.* at 78. A variation of this idea of moral rather than coercive enforcement was to reappear. It is said to have been argued in *Darling* that "if licensing and accrediting bodies are satisfied that their regulations are being met," the courts should not interfere. Foster, *Illinois Case Extends Hospital Liability*, 103 MOD. HOSP., Sept. 1964, at 95. In *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302, 309, 350 A.2d 534, 538 (1975), the New Jersey Hospital Association argued that competence should be determined exclusively by the "hospital and its related personnel," not by the courts. And in *Johnson v. Misericordia Community Hospital*, 99 Wis. 2d 708, 733, 301 N.W.2d 156, 169 (1981), the hospital argued unsuccessfully that a statutory declaration of its "moral obligation" negated its common law duty of care. Such faith in conscience and contrition might call for recitation of the General Confession in the Book of Common Prayer: "We have left undone those things we ought to have done; And we have done those things which we ought not to have done; And there is no health in us."

70. E. CODMAN, *THE SHOULDER* xii (1934). Dr. Codman wistfully recalled the "End Result Idea" as "the great and still unsuccessful interest of my life, over which I have toiled harder and suppressed more regrets, than over any other star-gazing period of my career." *Id.* See also L. Davis, *supra* note 65, at 116; Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care*, 129 W.J. MED. 443, 445-46 (1978).

71. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 131-32, 105 N.E. 92, 94 (1914).

72. *Alden v. Providence Hosp.*, 328 F.2d 163, 166 (D.C. Cir. 1967) (hospital liable for negligence of employed physician, chief medical resident; dissent that hospital did not treat patient). *Flagiello v. Pennsylvania Hosp.*, 417 Pa. 486, 519, 521, 208 A.2d 193, 209, 210 (1965) (charitable immunity abolished; dissent, "[Hospitals and public charities] are, next to the Church, the greatest benefactors known to mankind . . . and . . . always have been favorites of the law . . .").

73. C. JACOBS, T. CHRISTOFFEL, & N. DIXON, *MEASURING THE QUALITY OF PATIENT CARE* 24 (1976).

74. L. DAVIS, *supra* note 65, at 221. Goldberg, *supra* note 70, at 445.

professional work and who would "review and analyze at regular intervals their clinical experiences." This was a "goal to seek" so that the public could know to which hospitals they could go with safety.⁷⁵ The "minimum standard" evolved eventually into the accreditation standards of the Joint Commission on Accreditation of Hospitals beginning with a statement of the "minimum essential" in 1951 and currently stating the "optimal achievable."⁷⁶ The most important for the instant purposes are those requiring hospital medical staffs to ensure that each member is qualified, and that the staff "strive to maintain the optimal level of professional performance" and "provide mechanisms for the regular monitoring of medical staff practice and functions."⁷⁷

The forty-year gap between the beginnings of Dr. Codman's efforts and those of the Joint Commission has been ascribed to attitudinal, sociological and political factors rather than to technological difficulties.⁷⁸ Two facts are clear: between 1910 and 1965 the evaluation of patient care by private staff physicians was not compelled by court opinions; and the eventual infiltration into the courts of the concept that a hospital had some responsibility for a staff physician's conduct resulted from their recognition that a hospital's changed role had made the old precedents obsolete. But abandonment of old learning is hard for lawyers.

[J]ust as the clavicle in the cat only tells of the existence of some earlier creature to which a collarbone was useful, precedents survive in the law long after the use they once served is at an end and the reason for them has been forgotten.⁷⁹

The English cases are particularly illustrative. After *Hillyer* and *Schloendorff* the English and American cases do not refer to each other,⁸⁰ but they reach parallel results for parallel reasons. Thus, comparison of the two groups demonstrates the futility of resisting an idea whose hour has come, and they are cited for their analytical rather than precedential value.

The notion from *Glavin* and *Hillyer*, adverted to in *Schloendorff*, that a hospital was not liable for the professional negligence of its employees such as nurses, interns or physicians but only for their administra-

75. L. DAVIS, *supra* note 65, at 204; Goldberg, *supra* note 70, at 445-46.

76. AMH, *supra* note 5, at ix-xi. "There is no adequate work on the standardization movement which grew out of the scientific orientation most marked in the medical and surgical specialties." M. VOGEL, *THE INVENTION OF THE MODERN HOSPITAL, 1870-1930* at 148 n.34 (1980).

77. AMH, *supra* note 5, at 93, 106.

78. C. JACOBS, *supra* note 73, at 24-25.

79. O. HOLMES, *THE COMMON LAW* 31 (M. Howe ed. 1963).

80. *But see* Rabon v. Rowan Mem. Hosp., Inc., 269 N.C. 1, 5, 152 S.E.2d 485, 488 (1967) (charitable immunity abolished; hospital liable for medical negligence of nurse); Comment, *Private Hospital Held Liable for Medical Negligence of Professional Staff*, 57 COLUM. L. REV. 1041, 1043 n.23 (1957). Neither develops the references to English authority.

tive or ministerial negligence, leads to absurd results. A hospital would be liable if a nurse, in her capacity as a waitress, scalded a patient by spilling hot tea on him but would not be liable if, as a nurse, she negligently dosed him with poison.⁸¹ This was a paradox that could not be tolerated forever. Although a standard legal encyclopedia, *Halsbury's Laws of England*, had said, citing *Hillyer*, that a hospital was not liable for the professional negligence of its nurses, the statement was refuted by none other than Arthur Lehman Goodhart, Professor of Jurisprudence at Oxford and later Master of University College, who suggested "the law is almost exactly the opposite" and a "hospital is liable for the negligence of its trained nurses."⁸² Nothing from his pen was to be taken lightly, nor was it. Despite the traditional aversion of English courts to cite the works of living authors, Goodhart's article, *Hospitals and Trained Nurses* became a basis of *Gold v. Essex C.C.*⁸³

In *Gold* a little girl's face was disfigured through the negligence of a competent but careless radiographer, an employee. The court rejected the professional-administrative dichotomy, held the hospital liable, and set the stage for the erosion of the idea that the relationship between a hospital and its professional employees did not impose "the ordinary duty of a person who deals with another through his servants or agents."⁸⁴ In *Collins v. Hertfordshire County Council*,⁸⁵ a hospital was held liable for the combined negligence of a student nurse and a pharmacist in the injection of a lethal dose of cocaine instead of the procaine that had been ordered. "[T]he case of *Hillyer* . . . is no longer a binding authority."⁸⁶ And in *Cassidy v. Ministry of Health*⁸⁷ a hospital was held liable for the negligence of an employed physician who received a patient with two stiff fingers and sent him out with four—a useless hand. *Cassidy* repudiates the idea that a hospital cannot be responsible for the acts of physicians simply because it cannot control them and adopts the principle that hospitals have responsibilities for the treatment of patients:

[A]uthorities who run a hospital . . . are in law under the selfsame duty as the humblest doctor; whenever they accept a patient for treatment they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves; they have no ears to listen through the stethoscope, and no hands to

81. *Gold v. Essex C.C.* [1942] 2 K.B. 293, 302-03, 312-13.

82. Goodhart, *supra* note 54, at 553. This is said to be the most famous of Goodhart's articles. Baker, *A.L.G.: An Editor's View*, 91 LAW Q. REV. 463, 464 (1975).

83. [1942] 2 K.B. at 297.

84. *Hillyer v. Governors of St. Bartholomew's Hosp.*, [1909] 2 K.B. 820, 828-29.

85. [1947] 1 K.B. 598.

86. *Id.* at 616.

87. [1951] 2 K.B. 343.

hold the surgeon's knife. They must do it by the staff they employ; and if their staff are negligent in giving treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. . . .

It is no answer for them to say that their staff are professional men and women who do not tolerate any interference by their lay masters in the way they do their work. The doctor who treats a patient in the Walton Hospital can say equally with the ship's captain who sails his ship from Liverpool, and with the crane driver who works his crane in the docks, 'I take no orders from anybody.' That 'sturdy answer,' as Lord Simonds described it, only means in each case that he is a skilled man who knows his work and will carry it out in his own way; but it does not mean that the authorities who employ him are not liable for his negligence. . . . The reason why the employers are liable in such cases is not because they can control the way in which the work is done—they often have not sufficient knowledge to do so—but because they employ the staff and have chosen them for the task and have in their hands the ultimate sanction for good conduct, the power of dismissal.

This all seems so clear on principle that one wonders why there should ever have been any doubt about it. Yet for over thirty years—from 1909 to 1942—it was the general opinion of the profession that hospital authorities were not liable for the negligence of their staff in the course of their professional duties.⁸⁸

Some American jurisdictions had ignored the professional-adminis-

88. *Id.* at 603 (Denning, L.J.). Lord Denning relates the pathetic circumstances of *Gold and Cassidy* in his little memoir. A. DENNING, *THE DISCIPLINE OF LAW* 237-41 (1979). His reference to a ship's captain is not to the "captain of the ship" doctrine known to American malpractice law. See J. KING, *THE LAW OF MEDICAL MALPRACTICE* 243 (1977). Lord Denning was referring to the general rule that the employer of a ship's captain is responsible for the negligence of the captain despite the owner's inability to control him. The critical issue is employment, not control. *Hibbs v. Ross*, 1 L.R.-Q.B. 529, 542 (1866). Although ability to control may be a basis of liability, inability to control does not inevitably lead to nonliability. *Cf. River Wear Comm'rs v. Adamson*, [1877] 2 A.C. 743, 741. The irrelevance of control is very old. *Cf. Boson v. Sandford*, 91 Eng. Rep. 382 (1691). See generally, 35 HALSBURY'S *LAW OF ENGLAND, Shipping and Navigation* ¶1056 at 703 (3d ed. 1961). The American law is the same. *The Steamboat New World v. King*, 57 U.S. (16 How.) 469, 475-76 (1853). *Glavin's* dictum that liability depended on control, 12 R.I. at 424, 430-31, resulted in the special rule for hospitals. Exemption from liability by "reason of superior knowledge and skills of the servant has never been applied in other situations." Skill is a test "without legal or logical basis." Bobbé, *Tort Liability of Hospitals in New York*, 37 CORNELL L. REV. 419, 421, 428 (1952). See also Cunningham, note 92 *infra*, at 534-35. "[T]he modern and proper basis of vicarious liability of the master is not his control or fault but the risks incident to his enterprise." *Hinman v. Westinghouse Elec. Co.*, 2 Cal. 3d 956, 960, 471 P.2d 988, 990, 88 Cal. Rptr. 188, 190 (1970). Continental law is said to be similar. Kahn-Freund, *Servants and Independent Contractors*, 14 MOD. L. REV. 504, 508 (1951).

The "captain of the ship" doctrine is typically a device to impose liability on a surgeon for negligence of operating room personnel. *McConnell v. Williams*, 361 Pa. 355, 362 n.*, 65 A.2d 243, 246 n.1 (1949). It is a way of obtaining recovery from a physician when a hospital is protected by charitable immunity. Note that the immunity was not abolished in Pennsylvania until 16 years after *McConnell*. *Flagiello v. Pennsylvania Hosp.*, 417 Pa. 486, 208 A.2d 193 (1965).

trative dichotomy,⁸⁹ but it survived in New York until *Bing v. Thunig*,⁹⁰ that "brilliant opinion,"⁹¹ "the fall of the citadel" of hospital immunity.⁹² In *Bing* a patient was burned during surgery because nurses had negligently failed to remove sheets on which an inflammable antiseptic was spilled. The hospital defended on two grounds: that the nurses had acted in a medical or professional capacity and on its charitable immunity. The Court of Appeals rejected both defenses. The dichotomy had become so riddled with distinctions from which there could be deduced "neither guiding principle nor clear delineation of policy,"⁹³ as shown by what has been called a "perhaps colored catalog of [its] anomalous results."⁹⁴ This disparagement seems undeserved, because some of the examples such as employers' liability for the conduct of uncontrollable employees, such as airplane pilots and locomotive engineers, are no more extreme than those that already occurred to the English judges, and are the sort that would occur to any objective inquirer who asked why hospitals were the beneficiaries of special rules. And, as in *Gold v. Essex C.C.*, the court proceeded, contrary to *Hillyer*, to impose "the ordinary duty of a person who deals with another through his agents."⁹⁵ Starting from the proposition that a hospital treats patients and does not merely procure professional employees to act on their own responsibility or provide facilities in which someone

89. *Silva v. Providence Hosp.*, 14 Cal. 2d 762, 781, 97 P.2d 798, 808 (1940) (charitable immunity abolished; hospital liable in bed-rail case without regard to whether decision to omit rails was by nurse or doctor; *Schloendorff* cited in dissent); *Brown v. La Societe Francaise de Bien Faisance Mutuelle*, 138 Cal. 475, 71 P. 516 (1903) (hospital liable for negligence of employed physician); see *Garfield Memorial Hospital v. Marshall*, 204 F.2d 721, 725 (D.C. Cir. 1953) (hospital liable for acts of employed physician; California dictum followed); *Rice v. California Lutheran Hosp.*, 27 Cal. 2d 296, 304, 163 P.2d 860, 865 (1945) (hospital liable for professional acts of nurses and physicians despite argument based on *Schloendorff*); 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* §26.11 at 1397 n.9 (1956).

90. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

91. *Brown v. Moore*, 247 F.2d 711, 717 (3d Cir. 1957) (hospital liable for negligence of employed physician). See *Moeller v. Hauser*, 237 Minn. 368, 376-77, 54 N.W.2d 639, 645-46 (1952) (premonition of *Bing*).

92. Cunningham, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians* in *HOSPITAL LIABILITY* 532 (M. Bertolet and L. Goldsmith eds., 4th ed. 1980) (detailed analysis of *Brown*, 138 Cal. 475, 536-40, 97 P.2d 798, 551-52).

93. 2 N.Y.2d at 661, 143 N.E.2d at 5, 163 N.Y.S.2d at 6.

94. Note, *Hospital Liability in New York Court of Appeals: A Study in Judicial Methodology*, 61 COLUM. L. REV. 871, 881 n.50 (1961). *Bing* should also dispose of the "antiquated [and] rather meaningless notion that a corporation cannot practice medicine." SOUTHWICK, *supra* note 25, at 197, 412; Cunningham, *supra* note 92, at 530 nn.31, 33. Inability to do an act does not preclude liability for another's doing of the act. "Otherwise it is difficult to see how any corporate body could ever be liable for the acts of their servants." *Gold v. Essex C.C.*, [1942] 2 K.B. 293, 312.

If we were to rule that *respondeat superior* does not apply because the hospital is not licensed as a Nurse, then it would seem to follow that an airline should not be liable for the negligence of its pilot because the airline is not licensed to fly an aircraft. *Bernardi v. Community Hospital Association*, 166 Colo. 280, 291, 443 P.2d 708, 713 (1968) (applying *Bing*).

95. *Cf.* [1909] 2 K.B. at 828-29.

else may act,⁹⁶ the court concluded:

The doctrine of *respondeat superior* is grounded on firm principles of law and justice. Liability is the rule, immunity the exception. . . .⁹⁷ Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of *respondeat superior*.⁹⁸

The rule of nonliability is out of tune with the life about us, at variance with modern-day needs and with concepts of justice and fair dealing. It should be discarded. . . .⁹⁹

In sum, then, the doctrine according the hospital an immunity for the negligence of its employees is such a rule, and we abandon it.¹⁰⁰

Of course, until hospitals were held liable for the professional negligence of their employees, they would not be liable for the acts of non-employees such as staff physicians. But liability for the acts of employees does not mean that they are also liable for the acts of non-employees. *Bing v. Thunig* was thus an indispensable, but not a complete, basis for imposing liability on hospitals for acts of staff physicians retained by patients.¹⁰¹ Under *Schloendorff* a staff physician selected by the patient could, despite *Bing*, still be considered "an independent contractor, following a separate calling . . . involving the hospital in no liability. . . ."¹⁰² Unless one recognizes that the hospital treats patients, i.e., that the doctor is not following a "separate-calling" from that of the hospital, it would be a routine invocation of the old idea that the employer of an independent contractor is not liable for the latter's negligence. But this conventional rule is subject to many exceptions "whose very number is sufficient to cast doubt upon the validity of the rule" itself.¹⁰³ For example, the employer of an independent contractor

96. 211 N.Y. 125, 130, 132, 105 N.E. 92, 94 (1914).

97. 2 N.Y.2d at 656, 143 N.E.2d at 3, 163 N.Y.S.2d at 3 (1957).

98. *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

99. *Id.* at 667, 143 N.E.2d at 9, 163 N.Y.S.2d at 12.

100. *Id.* Compare *Bing* with the language in *Schloendorff*:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

211, N.Y. at 129, 105 N.E. at 93, *Schloendorff* lives on as a basis for the present law of informed consent. J. KATZ & A. CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? 80 (1975).

101. No English case on liability of a hospital for negligence of a physician selected by a patient has been found. The dicta say that there is no liability. See *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, 362 (liability said to depend on who pays the physician); *Gold v. Essex C.C.*, [1942] 2 K.B. 293, 302 (hospital not liable for negligence of consulting physicians and perhaps not liable for that of house physicians). See also Kahn-Freund, *supra* note 88 at 508; 30 HALSBURY'S LAWS OF ENGLAND, *The Medical Profession and Medical Practice* ¶40, n.7 at 36 (4th ed. 1980). But HALSBURY'S is not infallible. See Goodhart, *supra* note 54, at 553. And the further dictum in *Gold*, that a hospital might not be liable for house physicians, was not followed in *Cassidy*.

102. *Bing v. Thunig*, 211 N.Y. 125, 129, 105 N.E. 92, 93; *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 722, 301 N.W.2d 156, 163 (1981).

103. W. PROSSER, *supra* note 16, §71 at 468. See generally RESTATEMENT (SECOND) OF TORTS §§409-29 (1965). Section 409 states a general rule of non-liability, and the following twenty sec-

may be liable for his own negligence in selecting an incompetent,¹⁰⁴ or for failure to supervise a concessionaire,¹⁰⁵ or for his own breach of a non-delegable duty of care. A hospital has a non-delegable duty to keep its premises safe. Thus, when a patient fell in a bath because she was alarmed by a rat, the hospital did not escape liability simply because it had employed an exterminator as an independent contractor.¹⁰⁶ It would be a strange rule of law that would make a hospital more liable for rats than for accepting or retaining deficient physicians on its medical staff. Delegation to the staff of the duties of selection and retention of its own members is no defense because the medical staff is an agent of the hospital, and the hospital, therefore, remains responsible for the staff's negligence.¹⁰⁷ And the staff itself, as an unincorporated association, may be liable and sued as an entity.¹⁰⁸

These examples are intended to make obvious the distinction between the vicarious liability of hospitals for the acts of employees and liability for their own, or corporate, negligence. The hospital is liable for the acts of an employee whether or not it was itself negligent. But it is not liable for the act of a staff physician merely because he commits malpractice within the hospital;¹⁰⁹ the hospital is liable for negligence, for example, appointing a physician to the staff or failing to review his work; if it knew or should have known the physician might commit an

tions state exceptions thereto. Indeed, the Restatement says its "general rule" of nonliability of employers of independent contractors "is now primarily important as a preamble to the catalog of its exceptions." *Id.* §409, comment b. PROSSER, *supra*, says there are twenty-four exceptions. Whichever number is correct, the statement in SOUTHWICK, *supra* note 25, at 350, that the courts have "circumvented" the defense of independent contractor, has an unwarranted pejorative quality. What the defense now seems to mean is that a hospital is not liable for a staff physician's "collateral negligence." RESTATEMENT, *supra*, §426, illustration 3; *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, 364-65. Thus if an employee scalds a patient with hot tea, the hospital is liable. But if a private physician, as a gracious act, serves a patient and scalds him, the hospital is not liable, unless, of course, it had reason to know he was often careless. RESTATEMENT, *supra*, §411; 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* § 26.11 at 1407 n.51, 1410 (1956).

104. RESTATEMENT (SECOND) OF TORTS §411 (1965).

105. *Id.* at §415 (1965).

106. *Hill v. James Walker Memorial Hosp.*, 407 F.2d 1036 (4th Cir. 1969); SOUTHWICK, *supra* note 25, at 404; W. PROSSER, *TORTS* §93 at 624 n.41 (4th ed. 1971).

107. *Joiner v. Mitchell County Hospital Authority*, 125 Ga. App. 1, 12, 186 S.E.2d 307, 308 (1971), *aff'd*, 229 Ga. 140, 142, 189 S.E.2d 412, 414 (1972). SOUTHWICK, *supra* note 25, at 196, 349. The administration of the hospital must "stimulate the medical staff" to review "the professional qualifications and performance of each individual staff physician." *Id.* at 411. Lord Denning rebuked himself for failing as counsel in *Gold v. Essex C.C.* to make clear the non-delegability of the duty of care. [1951] 2 K.B. 343, 363.

108. *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302, 350 A.2d 534 (1975); *St. John's Hosp. M.S. v. St. John Reg. M.C.*, 245 N.W.2d 472, 474 (S.D. 1976) (capacity of medical staff to sue hospital).

109. *Mayers v. Litow*, 154 Cal. App. 2d 413, 316 P.2d 351 (1957); *Fiorentino v. Wenger*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967). *Cf. Pogue v. Hosp. Auth.*, 120 Ga. App. 230, 170 S.E.2d 53 (1969), *reviewed by Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 141, 189 S.E.2d 412, 414 (1972) (hospital not liable for negligence of independent contractor operating emergency service where failure to supervise contractor not raised as hospital's own negligence).

act of malpractice.¹¹⁰ The qualifying phrase "should have known" is necessary because if liability were restricted to cases of actual knowledge, "the less a hospital [knew] about a patient's condition, the safer it [would be] against charges of negligence."¹¹¹

Darling was not startling because it invented any new rules of law; it was startling because it applied the ordinary rules to hospitals and deprived them of the special privileges they once enjoyed, privileges that were designed to ameliorate the financial burdens of charities in cases where charitable immunity did not apply. When the immunity disappeared, the privileges were also destined for oblivion.

Despite the apprehensions it caused, *Darling* has not been the forerunner of a great number of other reported cases. The relatively few cases up to 1978 have been variously listed and analyzed,¹¹² and repetition here would be mere supererogation. But *Fiorentino v. Wenger*¹¹³ should be noted. It held only that a hospital was not liable for failure to ascertain that a surgeon had obtained the informed consent of a patient to a novel, indeed unique, surgical procedure.¹¹⁴ Otherwise, there was no claim of negligence on the part of the hospital.¹¹⁵ The court, however, delivered a dictum described as a "significant stride in developing" the *Darling* theory that a hospital has a "duty to monitor the quality of care rendered within its walls."¹¹⁶ "[A] hospital will not be held liable for an act of malpractice performed by an independently retained healer, unless it had reason to know that the act of malpractice would take place."¹¹⁷

At least two trial courts have acted on this dictum. In *Corleto v. Shore Memorial Hospital*,¹¹⁸ *Fiorentino* became a basis for allowing an action against not only the hospital but also its administrator, board of

110. [A] hospital has a direct and independent responsibility to its patients, over and above that of physicians and surgeons practicing therein, to take reasonable steps to (1) ensure that its medical staff is qualified for the privileges granted and/or (2) to evaluate the care provided.

Johnson v. Misericordia Community Hosp., 99 Wis.2d 708, 725, 301 N.W.2d 156, 165 (1981).

111. Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 94, 173 N.W.2d 881, 884 (1970); 99 Wis.2d 708, 739-44, 301 N.W.2d 156, 171-73 (1981).

112. E.g., W. CURRAN, *supra* note 23, at 364-90, 474-81 (3d ed. 1982) (with copious references to periodicals); HOSPITAL LIABILITY, *supra* note 92, *passim*; SOUTHWICK, *supra* note 25, *passim*; Copeland, *supra* note 24. The two Wisconsin opinions seem to list all the relevant cases. 99 Wis.2d 708, 301 N.W.2d 156 (1981), *aff'g*, 97 Wis.2d 521, 294 N.W.2d 501 (1980).

113. 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

114. For similar holdings see Cox v. Hayworth, 283 S.E.2d 392, 395 (N.C. App. 1981), and Cooper v. Curry, 92 N.M. 417, 420, 589 P.2d 201, 204 (1979).

115. Fiorentino v. Wenger, 26 A.D.2d 693, 694, 279 N.Y.S.2d 557, 559 (1966) (dissent).

116. Dunn, *supra* note 24, at 16.

117. 19 N.Y.2d at 415, 227 N.E.2d at 299, 280 N.Y.S.2d at 378. The holding of nonliability for allowing the experimental surgery has been questioned. W. CURRAN, *supra* note 23, at 480. But H. Leslie Wenger had outstanding qualifications and was a vice president of the Euthanasia Society of America. New York Times, Feb. 11, 1975, at 42, col. 3.

118. 138 N.J. Super. 302, 311, 350 A.2d 534, 538 (1975).

directors and medical staff based on allegations that they should have known that the operating physician was incompetent and nevertheless permitted him to remain on a case obviously beyond his control. The author relied on *Fiorentino* in *Gonzales v. Nork* which, although unreported, received much publicity.¹¹⁹ The *Nork* case, as it is usually called, involved a hospital allowing a surgeon to perform a laminectomy despite a history of bad results in that hospital. It has been described as the first case in which "a hospital was held liable for failure to adopt procedures to monitor the quality of medical care provided by a physician in the hospital."¹²⁰ In retrospect the author views it as also a case of the hospital's neglect in failing to use even the inadequate review procedures available in the late 1960's¹²¹ or, to paraphrase Professor Southwick, its liability for failure to "stimulate" its medical staff to perform its peer-review responsibilities.¹²² Whichever characterization is correct, as a result of *Nork* the Joint Commission on Accreditation of Hospitals is said to have adopted new accreditation standards,¹²³ now found in its manual under "Quality Assurance."¹²⁴

The hospitals settled in both *Corleto* and *Nork*.¹²⁵ If these settlements were efforts to suppress awkward holdings, they have been unsuccessful as shown by the three latest opinions to come to hand: *Johnson v. Misericordia Community Hospital*,¹²⁶ *Fridena v. Evans*,¹²⁷ and *Bost v. Riley*.¹²⁸ *Johnson* held a hospital liable for the malpractice of an incompetent surgeon whom it had appointed to the staff without investigation. *Fridena* held one liable for negligent supervision of a surgeon. And *Bost*, in effect, applied the ordinary rules to benefit the

119. Most of the opinion is reprinted in S. LAW & S. POLAN, PAIN AND PROFIT 215-45 (1978). The references to *Fiorentino* are at 241 and 244. Other extracts are in Copeland, *supra* note 24, 5 N. Ky. L. Rev. at 74-75. For general references see SOUTHWICK, *supra* note 25, and HOSPITAL LIABILITY, *supra* note 92. Accounts of the case are in 29 Citation 18 (1974) and Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care*, 129 W.J. Med. 443 (1978). The reference to reversal by the intermediate appellate court for holding Dr. Nork had waived a jury trial in SOUTHWICK, *supra* note 25, at 421 n.188, is wrong. The correct citation is *Gonzales v. Nork*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978) (affirming waiver of jury). See S. LAW, *supra* at 215 n.*. For an example of the notoriety of the case see S. BOK, LYING 155 (1978). The first California appellate opinion upholding corporate responsibility of a hospital appeared after this paper had been sent to the press. *Elam v. College Park Hospital*, 132 Cal. App.3d 332, 183 Cal. Rptr. 156 (1982). The author's opinion in *Nork* is said to "articulate almost precisely the same standard as the *Elam* opinion." CALIFORNIA MALPRACTICE TOPICS n.3 (D. Rubsamen ed. June 1982).

120. S. LAW, *supra* note 119, at 52.

121. S. LAW, *supra* note 119, at 245.

122. SOUTHWICK, *supra* note 25, at 349, 411.

123. S. LAW, *supra* note 119, at 65; Copeland, *supra* note 24, at 75.

124. AMH, *supra* note 5, at 151.

125. S. SHARPE, S. FISCINA & M. HEAD, LAW AND MEDICINE 658 n.18 (1978) (*Corleto*); 29 Citation 19 (1974) (*Nork*).

126. 99 Wis.2d 708, 301 N.W.2d 156 (1981), *aff'g*, 97 Wis. 2d 521, 294 N.W.2d 501 (1980).

127. 127 Ariz. 516, 622 P.2d 463 (1981).

128. 44 N.C. App. 638, 262 S.E.2d 391 (1980).

hospital. The hospital had failed to enforce its rule requiring surgeons to keep progress notes, which would be at least evidence of negligence. But there was no showing that this failure contributed to the patient's death from complications of a splenectomy. Therefore, under the ordinary rules of legal causation, the negligence was not actionable.¹²⁹ "Negligence in the air, so to speak, will not do."¹³⁰

In addition, "the view espoused in *Darling* has been embodied in the statutory law of several states."¹³¹ Elsewhere, including California, it may be found in administrative regulations having the force of law which make a hospital, through its medical staff, responsible for the quality of care of its patients.¹³² It is also reflected in the requirements of the Joint Commission¹³³ and hospital rules,¹³⁴ but these may be only a grudging acceptance of the inevitable. For a while, after *Nork*, the Joint Commission's standard on Quality of Professional Services was imperative,¹³⁵ but it has since been qualified by precatory phrases.¹³⁶ Some patients' bills of rights state hospital patients are entitled to "considerate and respectful care,"¹³⁷ but only the Pediatric Bill of Rights states expressly that they are entitled to "competent health care."¹³⁸ And although the prefatory statement to the American Hospital Association's version of a bill states, "Legal precedent has established that the institution itself . . . has a responsibility to the patient," at the end of the bill is the added statement: "No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect."¹³⁹ Unless one reads the word "guarantee" in a strict technical sense, the last

129. Thus failure to investigate competence is not a basis of liability where investigation would have disclosed no reason for refusal of staff appointment. *Ferguson v. Gonyaw*, 64 Mich. App. 685, 698, 236 N.W.2d 543, 550 (1976).

130. *Renslow v. Mennonite Hosp.*, 67 Ill. 2d 348, 355, 367 N.E.2d 1250, 1254 (1977) (hospital liable for preconception injury caused by transfusion of Rh positive blood).

131. *SOUTHWICK*, *supra* note 25, at 413, lists Michigan, Indiana and Arizona. See *Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 170, 500 P.2d 1153, 1158 (1972).

132. 22 CAL. ADM. CODE §§70701, 70703 (1975).

133. AMH, *supra* note 5, at 56.

134. *E.g.*, UNIVERSITY OF CALIFORNIA SAN FRANCISCO HOSPITALS AND CLINICS, BYLAWS, RULES AND REGULATIONS OF THE MEDICAL STAFF 5, 21-22 (1979).

135. The hospital shall demonstrate that the quality of care provided to all patients is consistently optimal by constantly evaluating it through reliable and valid measures. Where the quality of patient care is shown to be less than optimal, improvement in quality shall be demonstrated.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 143 (1979).

136. The hospital shall demonstrate a consistent endeavor to deliver patient care that is optimal within available resources and consistent with achievable goals. A major component in the application of this principle is the operation of a quality assurance program.

AMH, *supra* note 5, at 151.

137. W. CURRAN, *supra* note 23, at 750, 753, 762-63, 764.

138. W. CURRAN, *supra* note 23, at 757.

139. W. CURRAN, *supra* note 23, at 750, 751.

sounds like a disclaimer. Standard consent forms continue to recite that "all physicians furnishing services to the patient . . . are independent contractors and are not employees or agents of the hospital" but are the patient's "agents, servants or employees."¹⁴⁰ Even if the patient read and understood what such phrases are intended to mean, i.e., his consent was "informed," they would not exculpate the hospital from liability for its own negligence in appointment of incompetents, or in failure to monitor the care delivered by its medical staff.¹⁴¹

Johnson refers to "the common law duty of care owed to patients by the hospital,"¹⁴² and *Fridena* to its "inherent responsibilities regarding the quality of medical care furnished to patients within its walls."¹⁴³ What these mean are that the courts, not the medical profession or the custom of the community, will ultimately determine the standards of care. Custom may be evidence of due care but it is not conclusive, for there are precautions so imperative that even their universal disregard will not excuse their omission.¹⁴⁴ The courts will not determine those precautions solely by a logical process; they will determine them by the experience and felt necessities at the time of the decision. What they now recognize is

the public's perception of the modern day medical scientific research center with its computed axial tomography (CAT-scan), radio nucleide imaging thermography, microsurgery, etc., formerly known as a general hospital, [and that the] public is indeed entitled to expect quality care and treatment while a patient in our highly technical and medically computed hospital complexes.¹⁴⁵

In short, hospitals having shown what they can do have themselves established a standard of what they should do. And since what they can and should do depends on constantly changing facts, no effort has been made here to give a catalogue of hospital do's and don'ts. What has been shown is one example of the malleability of the law in response to changes in society and technology. This is not peculiar to the law relevant to medicine. Former Justice Potter Stewart, speaking of United States Supreme Court decisions generally, says, "They reflect nothing more than what was on the mind of contemporary America. Those

140. *E.g.*, CALIFORNIA HOSPITAL ASSOCIATION, CONSENT MANUAL 21 (conditions of admission), 41 (consent to surgery etc.) (10th ed., revised May, 1981).

141. *Tunkl v. Regents of Univ. of Cal.*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963); but *cf.* *SOUTHWICK*, *supra* note 25, at 423.

142. 99 Wis. 2d at 733, 301 N.W.2d at 169.

143. *Fridena v. Evans*, 127 Ariz. 516, —, 622 P.2d 463, 466 (1981).

144. *Darling*, 33 Ill. 2d at 331, 211 N.E.2d at 257.

145. *Johnson*, 99 Wis. 2d at 724, 301 N.W.2d at 164.

decisions are a reflection of American morality with a time lag."¹⁴⁶ And if this leaves one with a sense that the law is unpredictable, it is no more unpredictable than the society it depicts. "[C]ertainty generally is illusion, and repose is not the destiny of man."¹⁴⁷

146. As quoted in Reeves, *A Reporter at Large (Along Tocqueville's Path—Part I)*, THE NEW YORKER, April 5, 1982, at 77. For quite different examples of this phenomenon see Holman, *The Time Lag Between Medicine and Law*, 9 LEX ET SCIENTIA 102 (1972), reprinted in W. CURRAN, *supra* note 23 at 2.

147. Holmes, *The Path of the Law*, 10 HARV. L. REV. 457, 466 (1897).